Commonwealth of Kentucky
Cabinet for Health and Family Services
Office of Health Policy (OHP)

State Innovation Model (SIM) Model Design

Straw Person Supporting Document

June 2015

The following slides contain the meeting output notes from the KY SIM Stakeholder Workgroup sessions held in March, April, May, and June 2015.

Stakeholder input received in March, April, and May was used and refined by CHFS to develop the draft KY SIM Straw Person presented to the stakeholder workgroups in June. Stakeholder input received in June in response to the draft KY SIM Straw Person is being used to update and further develop the draft.

While much of this information has been incorporated into the draft KY SIM Straw Person, this document is primarily a reporting of facilitated workgroup topics only and does not reflect CHFS-endorsed proposals or policy prescriptions.

Improve Coordination, Connectivity & Transitions

March – June Workgroup Outputs

- Provide business process transformation technical assistance (TA) to provider practices
- Improve payer consistency in benefit design
- Incentivize physicians to have consumer needs discussions
- Increase Medicare and commercial insurance consistency for reimbursement of hospice care
- Increase earlier referrals from long-term care (LTC) to hospice
- Improve care coordination by co-locating services, integrating practices
- Conduct behavioral health screenings during physical health visits
- Identify housing needs of consumers
- Better coordinate care coordinators in the delivery system
- Engage faith communities as a community support option
- Increase education of health professionals about importance of oral health care to overall health of consumer
- Promote care coordination across all transitions in care
- Increase communication and information sharing in a timely fashion
- Create a person centered care plan across physical and behavioral health, and use analytics to monitor adherence
- Use Community Health Workers (CHWs) as a way of improving coordination of care
- Utilize oral health screening information obtained when students enter the public school system
- Include pharmacists, CHWs, and peer support specialists in the Health Home model

Improve Coordination, Connectivity & Transitions (Continued)

March – June Workgroup Outputs

- Establish relationships with community organizations and schools to make it easier for physical health providers to refer consumers
- Improve coordination between specialty care and critical access hospitals (CAHs)
- Coordinate immunization data with schools and Department of Education
- Better coordinate across payers on the continuum
- Encourage dietary counseling by a pediatrician or other health care provider
- Encourage team-based approaches to diabetes care
- Increase the frequency of referrals between providers and tobacco cessation programs
- Increase the use of schools as the “care coordinators” of environmental factors/daily activities
- Coordinate school policies statewide to have consistent messaging around tobacco use
- Leverage existing initiatives and centers of excellence to support diabetes care
- Increase and expand the training programs for law enforcement to include care coordination

Reduce Administrative Burdens

March – June Workgroup Outputs

- Standardize prior authorization criteria for diabetes-related drugs and products
- Build upon current programs used by hospitals/providers and assess readiness for new programs
- Streamline reporting across payers
- Make it easier for providers to prescribe tobacco cessation products and connect patients with smoking cessation programs
- Increase provider awareness/knowledge into patient's condition
- Explore the standardization of payer formularies
- Improve the provider licensing and credentialing processes
- Standardize language/translation services across payers

Expand Episodes of Care Payments

March – June Workgroup Outputs

- Allow providers in CMS pilots to expand to other payers
- Launch multi-payor episode of care pilot related to diabetes
- Expand risk agreements to all provider types
- Expand episodes of care across more parts of the delivery system
- Explore new episodes of care “owner” providers (e.g., post-acute care providers)

Developed Unified Quality Strategy

March – June Workgroup Outputs

- Standardize measure set and streamline reporting across multiple payers
- Adopt Medicaid managed care quality incentive program
- Obtain direct data feeds from payers/assimilate actionable data for providers
- Analyze more current data
- Select measures that are applicable across provider types and the care continuum
- Select measures that are patient-centric, understandable by patients, and allow for patient accountability
- Select measures that are achievable, risk adjustable, flexible, and easily measurable
- Select measures that are reliable and valid, clinically useful, and able to be benchmarked
- Develop outcomes and process measurement that align with national metrics
- Develop evaluation criteria that is self-reportable, inexpensive, address care spectrum, available, timely, complete, valuable and actionable, address priority health issues, and fair to all stakeholders. Align kyhealthnow with data collected from providers
- Improve measurement strategy of screening and counseling activities for tobacco
- Leverage provider-reported data within community health needs assessments in establishing quality measures
- Balance patient-reported data and accuracy with the need to have patients visit physicians
- Improve measurement strategy of screening and counseling activities
- Identify the effectiveness of screening and counseling provided by providers
- Additional consumer/advocate measures: convenience and “Am I better than when I arrived?”
- Incorporate monitoring and rapid-cycle evaluation

Increase Access to Services

March – June Workgroup Outputs

- Allow multiple visits on the same day
- Expand coverage of telemedicine and teledentistry
- Expand education and consumer awareness using non-traditional means
- Increase coverage for community wellness programs
- Leverage university health education and professional training programs
- Make existing networks more inclusive for different provider types (e.g., behavioral health providers)
- Expand health and wellness programs to the education system, worksites, childcare centers, etc.
- Increase acceptance of nutrition assistance at farmer's markets
- Improve diagnostic and preventive care through the use of telehealth
- Include providers in the development of standards on adequate provider communications using technology
- Expand the role of the Public Health dental hygienists
- Encourage team-based intervention around smoking cessation
- Identify these points are all types of "doors" (e.g., community, schools)
- Allow all provider types to be reimbursed for health and behavior codes
- Expand the use of telehealth as a way of increasing patient visits
- Provide more robust transportation to health homes
- Expand the use of grocery stores as a way of providing consumers with health information and healthy foods
- Improve patient access to care by co-locating services, integrating practices
- Implement telehealth across the care continuum, not just in rural areas

Increase Access to Services (Continued)

March – June Workgroup Outputs

- Increase tobacco use screening in all provider settings
- Implement new care models that support patient access to care and preventive education
- A meaningful reform of the dental program via Medicaid and the managed care organizations (MCOs) would work wonders to assist in eliminating these dental deserts
- Enable federally qualified health centers (FQHCs) to offer dependable and comprehensive behavioral health and dental services
- Increase the use of teledentistry by providers and hospital emergency departments (Eds) to reduce the impact of the costs of dental presentations to ED physicians that have little dental education for impactful treatment
- Improve capacity and/or utilization numbers (e.g., no-show rates)
- Increase access to certified diabetes educators in the state
- Promote community-based education that aligns with national policies from the CDC and other federal health agencies
- Increase tobacco cessation awareness education for adults
- Increase access to low-intensity diabetic services for all populations across the state
- Recognize rural areas within Metropolitan Statistical Areas (MSAs)
- Increase available transportation to fresh food sources
- Increase education and resources for breast feeding
- Allow food stamps to be used at farmers markets
- Utilize cooperative extension programs
- Focus on coordination across providers using telehealth
- Partner with physicians and specialists to increase the use of telehealth
- Increase the use of telehealth in the classroom as a way of identifying students in need of a referral

Expand Patient Centered Medical Homes (PCMH)

March – June Workgroup Outputs

- Provide infrastructure and training support to practices wanting to achieve PCMH
- Develop a multi-payer compensation model for PCMH
- Expand the scope and reach of the care team to include oral health, public heath, schools, pharmacists, physical therapists, CHWs, and community mental health centers (CMHCs), among others
- Take a broader approach to developing a care team, including additional resources and provider types
- Develop a “quick win” strategy to generate support
- Increase provider motivation through the use of incentives
- Focus on medication adherence and including pharmacists in care coordination
- Develop reimbursement methods that align with a holistic, whole person approach to care
- Create incentives for physicians to conduct initial oral health screenings
- Assign individuals leaving the corrections system to a PCMH
- Maintain a strong focus on prevention strategies within the PCMH
- Develop PCMH measures that align with existing measures (e.g., FQHC)
- Expand the scope of PCMHs to support increased health literacy and cultural competency
- Measure the effectiveness of transitions of care within the PCMH
- Develop a targeted consumer education and communication strategy
- Establish state-specific PCMH principles
- Recognize unfunded mandates
- Recognize social components in PCMH design
- Consider practice capacity to deploy an expanded care team

Expand Health Homes

March – June Workgroup Outputs

- Launch Health Homes statewide
- Assign individuals leaving the corrections system to a Health Home
- Explore the integration of physical and behavioral health within Health Homes
- Develop a targeted consumer education and communication strategy

Expand Accountable Care Organizations (ACOs)

March – June Workgroup Outputs

- Allow current ACOs to expand to multiple payers
- Allow creation of new Medicaid focused ACOs
- Expand scope of ACOs to more complex populations (LTSS)
- Expand scope of ACO care team to oral health, public heath, schools, pharmacists, physical therapists, CHWs, and CMHCs
- Increase provider coordination within and outside ACOs
- Create equal risk and gain sharing opportunities among all providers in the ACO
- Improve the lag in payments to ACOs
- Create information technology connections between oral and physical health within ACOs
- Develop a targeted consumer education and communication strategy
- Recognize physician limitations in an ACO model
- Encourage colocation to consider supply vs. demand and consumer needs

Enable Consumers

March – June Workgroup Outputs

- Implement pilot incentive program for healthy foods for children and adults
- Increase public transparency of provider prices
- Explore tax incentives for employees to participate in workforce wellness
- Expand consumer engagement via technology
- Increase health education/awareness using non-traditional means
- Enable and empower the consumer to make behavioral changes using technology, such as wearable technology
- Assist consumers with the navigation required for diabetes care
- Promote patient accountability and engagement around tobacco cessation through increased transparency of coverage options
- Promote the deployment of more in-home supportive technology for diabetic patients
- Explore the role of registries in consumer education/provider access to information
- Increase electronic access to consumer education (e.g., health literacy and promotion of behavior change)

Develop Unified HIT Strategy

March – June Workgroup Outputs

- Increase and improve patient tracking mechanisms
- Make consumers' care plans accessible through a common portal
- Use geomapping analytics to map community assets, such as grocery stores
- Inventory early detection, screenings, and prevention data
- Create actionable alerts for data end users
- Increase obesity-related data collection and transparency
- Examine an individual's connections to predict behavior/preempt change
- Develop more robust reporting and analytics of obesity
- Real-time data sharing (e.g., Medicaid claims) via EMRs
- Leverage national recognition of the Kentucky Health Information Exchange (KHIE) and kynect
- Leverage Kentucky Hospital Association (KHA)-type data collection service for inpatient and outpatient claims
- Stop gap funding for meaningful use data
- Gather body mass index (BMI) measures to track individuals at risk of becoming obese
- Increase resources devoted toward identifying and tracking patients at risk of developing diabetes
- Develop more robust and consistent reporting on consumer adherence to treatment plans
- Focus on standardization of data elements by creating a data dictionary, beginning with Kentucky's All Payer Claims Database (APCD) and/or encounter system
- Encourage the use of patient facilitators in helping consumers use technology to manage health care
- Identify ways technology can be used to modify the behavior of non-compliant patients
- Standardize the credentialing process across all payers

Develop Unified HIT Strategy (Continued)

March – June Workgroup Outputs

- Recognize the need for enhanced analytics
- Recognize the varying broadband infrastructure across the Commonwealth
- Recognize the cultural challenge and provider education needs in implementing new HIT
- Recognize the limitations of software vendors in terms of standards and interoperability

Leverage Regulatory Authority

March – June Workgroup Outputs

- Restrict smoking opportunities through policy changes for both children and adults
- Limit access to unhealthy foods
- Develop policies that provide resources to schools in order to prevent obesity before adulthood
- Leverage existing regional plans and policies that promote tobacco cessation
- Develop policies that encourage improved nutrition in schools and improve access to physical education
- Develop changes to regulations that restrict access to care

Implement Payment Reform

March – June Workgroup Outputs

- Demonstrate both short and long-term payer value
- Flexibility in medical necessity criteria and payments for non-clinical outcomes (e.g., quality of life)
- Increase reimbursement and adopt policies to encourage Medicaid patient acceptance
- Extend incentives to all provider types with the behavioral health system
- Consider different reimbursement practices for providers with different technology infrastructures
- Shift the use of funds for transportation to telehealth
- Consider the role of consumers in payment reform
- Ensure that payment reforms are tied into the value propositions for payers
- Encourage provider partnerships through payment reform
- Use payment reform to incentivize and/or disincentivize consumers

Identify Policy Levers to Improve Population Health

March – June Workgroup Outputs

- Increase focus on prevention in children/teens
- More actively engage payers in reducing tobacco use
- Engage employers to promote smoking cessation in their workforce
- Encourage providers to focus on social determinants to health
- Develop a multi-payer diabetes prevention program
- Establish methods for tracking adherence to tobacco cessation programs

Develop a Workforce Strategy

March – June Workgroup Outputs

- Encourage providers to practice at the top of their scope of practice
- Leverage the National Governors Association (NGA) data collection strategy
- Expand loan forgiveness to other professions (e.g., behavioral health providers)
- Implement early training based upon geographic location and/or communities
- Improve the difficulty of clinical placements by promoting health centers as teaching centers
- Conduct rural family physician identification early (e.g., high school)
- Leverage Area Health Education Center (AHEC) programs to reduce disparities among MDs, APRNs, PAs, etc.
- Provide financial support for practice transformation for providers “at-risk” of retirement
- Encourage in-state practice and maintenance of community relationships